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Integrating Canada's Dis-Integrated Health Care System

Lessons from Abroad

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In this issue...

Separate financing of different elements in Canada's publicly funded health system inhibits the development of integrated or "seamless" care. Putting more discretion over spending in the hands of regional health authorities, general practitioners, and/or consumers could encourage better quality treatment at lower cost.

The Study in Brief

Although integrated, or "seamless," health service provision is an attractive goal, the separate financing of different elements in Canada's publicly funded health care system inhibits its achievement. Health authorities and hospitals, doctors working in hospitals, and primary care doctors, for example, are each remunerated separately. Separate financing means that providers in each system tend not to take account of the costs and benefits of their actions to the system as a whole.

Reforms in other countries provide important guidance about how Canadians might better integrate their publicly funded system. Among the possibilities are:

- giving regional health authorities more discretion over their spending, with hospitals and other providers competing to provide services to the covered populations;
- converting hospitals into independently funded enterprises with enhanced powers over staffing and a mandate to compete to provide services to regional authorities or primary care doctors;
- putting more funds in the hands of primary care doctors, who would contract with hospitals and other providers for the services their patients receive; and
- putting funds in the hands of health care consumers to make them more active participants in cost/benefit decisions.

Alone or in combination, these reforms could locate more decisions "closer to the patient" and induce better quality at lower cost by creating a framework for provider and consumer decisionmaking that would align incentives better.

Previous experience suggests that, for such reforms to succeed, they require increased autonomy on the part of the new fund-holders and frameworks for genuine competition among providers. Careful pilot projects are also needed to distinguish changes in outcomes resulting from the reforms and those resulting from other causes, and to determine the institutional changes that will work in a Canadian environment. The promise of a better integrated publicly funded system, however, makes such tasks well worth the effort.

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Despite claims to the contrary, the Canadian health care system is not falling apart. The basis for this observation is that the system was never together in the first place! Some aspects of health care in Canada are financed privately and others publicly. However, the problem goes beyond a simple public/ private dichotomy. Within the publicly financed part of Canadian health care there are at least three systems: health authorities and the providers they manage (mainly hospitals); hospital doctors; and primary care doctors (general/family practitioners, known as GPs). Despite sharing the characteristic of being publicly funded, these systems are in fact remunerated separately. Consequently, they do not necessarily face the same incentives with respect to achieving some common goals for publicly financed health care.

Integration and "seamless health care" are fashionable ideas (Shortell, Gillies, and Anderson 1996). Many Canadian health authorities, in their strategic plans, even claim to be moving in this direction (Headwaters Health Authority 1998). However, health authorities can only do so much within the current funding structure of Canadian health care. In short, true integration can never take place without financial integration.

The aims of this paper are twofold. First, we show in detail that publicly funded health care in Canada is really three separate systems, and we discuss the perverse incentives this engenders. Then we review four major reforms, all intended to better integrate the financing of health care, that have been implemented elsewhere in the world. The common theme of these reforms is better alignment of financial incentives within health care. Each one puts the responsibility for major decisions, and the burden for bearing the financial consequences of these decisions, in the hands of one body. We assess each of these attempts at integration in terms of (1) the evidence regarding its effects on costs, health outcomes, and access to care; and (2) its potential for implementation in Canada.

The inspiration for most of these reforms comes largely from recent developments in European health care systems, in particular those of Sweden and the United Kingdom, as well as from New Zealand. All involve the creation of an internal market for health care, whereby responsibility for purchasing health care is separated from responsibility for providing it. Purchasers could be health authorities or GPs or even consumers, in the case of medical savings accounts, which have been tried in countries such as China and Singapore as well as in the United States. Therefore, much of the paper derives possible lessons for Canada from systems more closely related to our own than that in the United States, to which, perhaps, we in Canada tend to look too much.

It is worth noting at the outset that all the reforms we review take place *within* a publicly funded health care system. In this paper, we do not discuss reforms involving an increased or decreased role for private financing; these have been addressed by others (Ham 1996a). But if, as many observers think, Canadian health care is not sustainable in its current form, and if simply spending more is not the answer in the long term, the solution to maintaining medicare may lie in the implementation of some of the reforms we review here.

The Perverse Incentives of the Canadian Health Care "System"

In the absence of any specific policy decision, Canadian health care is gradually privatizing itself.

The data show quite clearly that Canada's health care system is really a collection of different systems. First there is the private system, which represents a significant — and increasing — portion of health care services in this country. Data from the Canadian Institute for Health Information show that the proportion of health care funded from private payments, either directly from consumers or through private insurance, grew from 25 percent in 1990 to 29 percent in 2000. In the absence of any specific policy decision, Canadian health care is gradually privatizing itself. This phenomenon may be a result of failures in the public system, or of government funding not keeping pace with the increasing potential of health care to treat more people and treat people more. The reasons are a matter for another paper.

As Table 1 shows, a substantial percentage of each category of health services is publicly financed. These services are administered for the most part through health authorities, who fund hospitals and other health care institutions. These institutions account for 41 percent of health care costs in Canada. Physicians are remunerated through a separate system, which accounts for 14 percent of costs. But the *decisions* of physicians, as we discuss below, have a much wider impact on costs than the remuneration of physicians themselves. The other large category of health services, drugs, is, as Table 1 shows, mainly accounted for by a system of private and public drug plans as well as out-of-pocket payments.

In the remainder of this section, we examine how the separate nature of these systems has led to perverse incentives within publicly funded Canadian health care. These "dys-incentives"[1] influence the behavior of health authorities, institutions (which we will characterize as hospitals), medical doctors, and members of the public when acting as patients.

Health Authorities: Responsibilities without Power

During the past seven years, most provinces in Canada have established health authorities. These authorities perhaps have been used as a vehicle for diffusing blame for tough financial decisions in publicly financed health care (Lomas, Veenstra, and Woods 1997). However, they also have had the laudable goal of providing services in line with the needs of the local population. They are responsible for assessing the needs of the population in a certain geographic region and for setting health care priorities in line with those needs (see Donaldson, Mitton, and Currie [forthcoming] for a more detailed explanation). In Canada, unlike in the United Kingdom and Sweden, as we discuss below, hospitals and many other providers are administered by the health authorities.

It could be argued that such authorities are best placed to perform the roles of needs assessment and health care planning. Many have been vilified in the popular press, however, for a lack of financial prudence. It may be that these authorities, which often inherited severely reduced financing and were relatively new to their

1 The spelling "dys-incentives" is deliberate. Unlike "disincentives," which discourage behavior, these are incentives to behave undesirably.

Table 1: ***Dollars per Capita and Percentage of Total Spent, Various Health Care Categories, 2000***

Category	Expenditures		
	$ per Capita	% Public	% of Total
Hospitals	983	92	31.8
Other institutions	291	70	9.4
Physicians	416	99	13.5
Other professionals	366	10	11.8
Drugs	478	33	15.5
Capital	112	89	3.6
Other expenditures	447	85	14.5
Total	3,094	71	100.0

Source: Canadian Institute for Health Information.

assigned task, were, indeed, imprudent. But the problem may be more complex. While these authorities' responsibility for the health of their local populations is well defined, their power over spending is limited. The structure of the Canadian health care system is such that they do not have enough control of resources within the system either to direct these resources in line with their priorities or to control the total amounts spent.

It is doctors, the people to whom patients present themselves (either in hospital or in general practice), who direct much of what happens in health care. Yet, doctors are remunerated independently of health authorities. For example, in Alberta, the provincial government decides on the total amount of money that will be made available to remunerate physicians across the province. The Alberta Medical Association, which represents both general practitioners and specialists, then decides on the fee schedule — that is, the rate at which doctors will be paid for each service. In part, these fees will determine what doctors do. All that health authorities can do is hope to influence physicians by involving them in discussions about infrastructure and compliance with the latest clinical practice guidelines.

Ultimately, it is doctors who control the movement of resources while, to put it crudely, health authorities have to pick up the tab. For example, if a physician orders a laboratory test or an X-ray, it is the health authority that carries the financial burden, not the physician. It may be that, if health authorities had control over the pot of money currently used to pay doctors' incomes, the behavior of health authorities and doctors would be more in line with each other. A mechanism for doing this — namely, a type of internal market or purchaser/provider split — is the first reform described in the next section. (Most of the reforms described below represent a variant on this internal-market concept.)

Providers: No Reward for Efficiency

Currently, hospitals in Canada are not rewarded for providing efficient service. For the most part, health authorities receive a budget from the provincial governments, usually based on a funding formula incorporating population size and indicators for need and simply pass on this money to hospitals and other providers of care. The hospitals and health authorities report back to provincial authorities regarding the number of services provided and their cost, but, in the main, the allocation process involves hospitals receiving what they had the previous year plus a little bit more. If a hospital, for example, achieves the same levels of patient outcomes as it did the previous year but with a shorter average length of stay and hence a lower cost, this may allow that hospital to treat more patients, but it will not be rewarded for being more efficient.

The current system of having hospitals and other community service providers actually run by the health authority may also encourage too much micro-management, such as the chief executive of the health authority making decisions about car parking at one of the local hospitals! An arm's-length arrangement might be more efficient, with micro decisions made at the micro level, lowering the costs of bureaucracy and leaving health authorities to get on with their main task of assessing the needs of their local populations and directing the system toward the priorities they set based on these assessments.

Hospitals, like health authorities, may not have enough control over doctors. Not only are the main drivers of resource use (that is, doctors) not actually employed by the organizations in which they work (that is, hospitals), they are not even *remunerated* by those organizations. This extraordinary arrangement, which rarely occurs elsewhere in the economy, likely evolved through historic accident rather than by design to serve any current need. It may in fact be appropriate; but without more financial integration — making the person directing resource use responsible for the costs of that resource use — it is unlikely that the behavior of the organization and of those working within it will be in line.

In this area, the UK and Swedish systems provide examples of an alternative arrangement. There, doctors are employed by the hospitals in which they work, although, at least in the United Kingdom, doctors can supplement their National Health Service (NHS) income by working in private hospitals.

Finally, neither hospitals nor health authorities have to account for the costs of their capital assets. Currently, these are treated as free goods; application is made to provincial governments for the funding of capital projects. This could lead to incentives to overstate capital requirements or, if the cap on such expenditures is too low, to an inefficient clinging to outdated buildings and equipment. A system where hospitals and/or health authorities were given a budget and subsequently had to account for capital costs might induce more efficient behavior in this regard.

Physicians: Power without Responsibility

With respect to decisions about health care resource use in Canada, physicians hold much of the power. The general public, with its natural suspicion of managers and administrators, may think this is a good idea. But it leads to some problems and may not actually be in the public's best interests. It is not our intention here to criticize the motives of the individual physician; rather, we are simply stating that, at present, the incentives to which physicians respond can result in inappropriate patient care and inefficient use of public resources.

Currently, the system by which physicians are rewarded — paying a set fee per service — gives them an incentive to generate demand for their own services.

Currently, the system by which physicians are rewarded — paying a set fee per service — gives them an incentive to generate demand for their own services. The doctor has the ability to generate this demand because he or she also acts as an agent for the patient. The demand generated under this system may not always be related to need. One is reminded here of the famous quote from George Bernard Shaw's *The Doctor's Dilemma*:

> That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on

> to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.

In a more logical system, a physician might receive an annual payment from which to finance a patient's primary care needs, with the patient tied to that doctor until the patient decides to change practice, taking along his or her annual payment, or a prorated portion of it. Such a system of reward would give physicians greater incentive to encourage, for example, patients in preventive activities related to lifestyle change.

Further, in primary care funded by fee per service, once the patient is in the physician's office, the fee is guaranteed. The physician has little financial incentive to spend time with the patient; instead, the system provides a doctor with an incentive to refer the patient on to a hospital or to reach for the prescription pad. Each of these is an action for which the physician bears no financial responsibility, and that may be wasteful and/or inappropriate care for the patient.

Consumers: Neither Power nor Responsibility

The structure of Canadian health care is such that, in discussions about health care planning between health authorities and providers (for example, hospitals), there is no role for consumers. Perhaps there are good reasons for this; one of the arguments often invoked to support extensive government intervention in the health care market is the lack of knowledge most consumers have about this important "good" (Evans 1984; Donaldson and Gerard 1993). Governments and health authorities therefore act on behalf of consumers to buy services from hospitals and doctors, exercising power on the demand side of the market to counterbalance the supply-side power vested in large institutions such as hospitals and in the medical profession (Evans 1987).[2]

Consumers, not having to pay any of the costs of health care directly, have an incentive to overuse it.

One result of this arrangement is that consumers, not having to pay any of the costs of health care directly, have an incentive to overuse it. We are not suggesting that all consumers necessarily request inappropriate care and drive inefficient use of resources; it is our intention solely to point out that the incentives inherent in the Canadian health care system as it now exists *allow* for such problems to arise. For example, because seniors in Alberta face a flat out-of-pocket deductible of $25 for prescription drugs funded by Blue Cross, they have an incentive to ask for these drugs to be dispensed to them in larger amounts than may be necessary (Walker 2000). Many of the drugs dispensed in bulk may never be consumed. Also, consumers often use hospital emergency rooms and walk-in clinics when a visit to a GP might be more appropriate. Finally, some patients are very high users of GP services.

User fees for health care consumers are one possible way of introducing a more logical incentive to the system. The RAND Health Insurance Experiment showed that people in health insurance plans with user fees used fewer services than those

2 On the other hand, consumers *do*, in fact, make decisions with regard to many areas of health care, such as dentistry, which may indicate that informational problems are not as serious as some think.

Table 2: ***Achieving Greater Financial Integration***

Type of Reform	Contractor	Contractee	Nature of Competition
Internal market with:			
1a. Health authorities as purchasers	health authorities	hospitals and other health care providers	potential exists for price and quality competition
1b. Hospitals as providers	health authorities	hospitals and other health care providers	price and quantity regulation possible if major disparities are exposed (e.g., in access to care for serious conditions)
Internal market with:			
2. GP fundholding	GPs	hospitals and other health care providers	potential exists for price and quality competition price and quantity regulation likely — see above
3. Medical savings accounts	consumer/patient	primary care doctors and other providers of routine services	potential exists for price and quality competition price regulation likely (e.g., for GP consultations) in interests of equity

in a plan with no user fees. However, about half of the demand that was choked off by user fees was for necessary treatments (Lohr et al. 1986).

On the other hand, health care is not a "good" that consumers necessarily like to use, and thus there is a psychological incentive against overuse; there is also a price to pay for health services in terms of time and waiting costs. Furthermore, problems such as the overuse of emergency rooms may stem from a lack of available primary care doctors rather than from patients simply choosing to visit an emergency room instead of a physician. Another concern is that the alternative to relying on consumer preferences to guide the demand side of the market is paternalistic. By definition, it is likely that services will not be provided in line with consumer preferences. Finally, it is important to bear in mind that there is not a lot of published evidence on this topic. It may be possible, however, to give consumers more power within a publicly funded system, and a method for doing this is outlined in the fourth reform we discuss below.

Achieving More Integration in Canadian Health Care

What we present above is, in some respects, a caricature of health care in Canada. There is no suggestion that the behavior of all physicians or consumers is actually ruled by the incentives we describe. Many other factors come into play. However, there may be enough of these perverse incentives, and they may be powerful enough, to induce a significant number of actors in the system to behave in ways that impose sizable costs on the system. The only way to prevent such inefficiencies is to remove the illogical incentives through greater financial integration.

Each of the ways in which greater financial integration can be achieved involves making clearer who purchases care (the contractor) and who provides care (the contractee).

Table 2 summarizes the three main ways in which greater financial integration — and, therefore, responsibility — can be achieved within publicly funded health care. Each involves making clearer who purchases care (the contractor) and who provides care (the contractee). Note that these three options are not mutually exclusive.

The first would involve putting more health care money, including the budget for physicians, in the hands of health authorities. Hospitals and other providers would then have to compete to win contracts from the health authorities. Reviewing the evidence on how this arrangement would work involves separate assessments of the roles of health authorities as purchasers of care and hospitals as providers of care in a quasi-market. We present these assessments in the following two sections.

The second way of achieving greater financial integration would be to put all health care money in the hands of GPs, who would then contract with hospitals and other providers for their patients' use of these services.

Finally, greater integration could be achieved by putting health care money, and thus greater responsibility for choice, in the hands of consumers/patients themselves. This is essentially the system that has been implemented in parts of the United States. It has been suggested that Canada adopt it in the form of medical savings accounts (Gratzer 1999).[3]

No matter what group is given responsibility for spending Canada's health care resources, there is still significant potential for regulating the market, especially if disparities in prices and/or in access to care for serious conditions arise, or existing disparities come to light. However, policymakers may expect the market itself to correct these disparities to some extent.

Health Authorities as Purchasers

The basis of an internal-market model is separating the purchasing of health care from its provision. The purchasing role can be performed by health authorities, which plan for and purchase services to meet the health care needs of the populations they represent, including emergencies and elective health care. Internal markets in health care have arisen most prominently in the United Kingdom, where they have existed since April 1991, but also in New Zealand, where they were introduced in July 1993 (United Kingdom 1989; New Zealand 1993). In Sweden, the 26 county councils were already responsible for health care, and some of them (numbering 12 by 1995) implemented internal market reforms throughout the 1990s by removing hospitals from county council control (Bergman 1998).

This arrangement frees health authorities from becoming bogged down with the minutiae of running facilities such as hospitals. Instead, they can focus on assessing the needs of their population and establishing contracts with various health care providers in line with their assessments of where the priorities lie. It

3 Note that while medical savings accounts have been implemented in the United States in recent years, they do not represent as substantial a reform as the introduction of managed care. Managed care is more like an internal market where a third party advises and makes purchasing decisions on behalf of enrollees.

also removes the perverse incentives of a system where health authorities pay the bills without being able to direct priorities, and are unable to reward efficient providers. The balance of power is realigned as at least one body takes a population perspective rather than having service provision driven by the existing bricks and mortar and the providers (mainly doctors) who work therein. With an internal market, health authorities hold the purse strings and choose between providers on the basis of quality and cost, rather than simply funding the decisions of those using the resources.

There are some differences in the ways in which internal markets were implemented in the three countries referred to above. In New Zealand and Sweden, health authorities can purchase GPs' services (Scott 1994; Bergman 1998). This was not the case under the UK reforms; most GPs there were eventually established as rival purchasers to health authorities (see below). In New Zealand, GPs were given control over budgets for drugs and laboratory procedures (Kent 1999). A further innovation introduced in New Zealand was the opportunity for individuals to take their share of public funding and place it in a health care plan, thus establishing another sort of rival purchaser to health authorities (Scott 1994). This last innovation did not really take off, however, whether because awareness of the option was not widespread or because the public was apathetic toward it.

Efficiency and Equity

There has been little rigorous evaluation of the role of health authorities as purchasers of care.

There has been little rigorous evaluation of the role of health authorities as purchasers of care. In the United Kingdom, all health authorities became purchasers at the beginning of the reforms, so there was little scope for comparative analysis. This area therefore "failed to capture the imagination" of researchers (Mays, Mulligan, and Goodwin 2000). The same is true in New Zealand (Ashton 1993; Scott 1994). But in Sweden, where county councils implemented this reform at different times, more scope existed for comparative analysis (Bergman 1998).

What is known is that the system of health authority purchasing in the United Kingdom, at least initially, mirrored the old system. In contrast, the practice of GPs shopping around for services in an attempt, for example, to reduce their patients' waiting times, had a more immediate impact. Health authorities, perhaps inevitably, were more influenced by policy directives from the central government (Hughes, Griffiths, and McHale 1997). Initially, in the main, block contracts were established between health authorities and providers (Raftery et al. 1996). These contracts were open ended with respect to levels of activity and expected outcomes, which, again, basically mirrored the old-style NHS. Only later did cost and volume contracts, which specified, among other things, the actual number of patients to be treated by a provider, become more established, although not on a widespread basis.

Central policy directives also hampered the pace of progress in New Zealand. Indeed, the failure of health authorities to generate competition partly led to their being replaced by a central agency, the Health Funding Authority (Kent 1999). A purchaser/ provider split was maintained, but one based more on cooperation

than competition, thus representing a backing away by the government from the original model.

Generally, the possibility for competition among providers did exist. For example, Appleby et al. (1994) show that only 8 percent of acute care hospitals in a major region of England (West Midlands) had a monopoly of their main surgical specialties within a 50 km radius.

Other than the constraints of policy directives from the central government as mentioned above, there are two other main reasons this potential to induce competition was not fulfilled by UK health authorities. First, the sheer enormity of the task may have prevented them from taking action. Unlike GPs, health authorities had to purchase the full range of health services. It is unlikely that they would have staff specialized enough to challenge the plans of providers (United Kingdom 1997). Second, the fear of destabilizing providers by making large resource shifts is likely to have inhibited many purchasers from making such shifts (Mays, Mulligan, and Goodwin 2000). This is not surprising given the politically charged atmosphere of health care provision.

The fact that Swedish county councils were less hampered by central directives, since they already held responsibility for health care funding and provision, probably led to more positive results for internal market reforms there. For example, Gerdtham, Rehnberg, and Tambour (1999) estimate that those county councils in which reforms were implemented reduced costs by about 13 percent relative to those that retained the status quo. Flood (2000) lends weight to this argument in her analysis of the UK and New Zealand reforms. She notes that central-government-appointed purchasers in internal markets have no incentive to engage in "aggressive" purchasing. Flood suggests going beyond the Swedish reforms, advocating a managed-care model where consumers have the power to choose a purchaser.

One should not be too pessimistic, however, about the impact of the reforms in the United Kingdom. Ham (1996b) describes important changes to health care in London in 1991. Given the city's population and its large number of hospitals, particularly relatively expensive teaching hospitals, London is precisely the place where one would have expected the UK reforms to have a significant impact. Indeed, this is what happened. Almost immediately after the reforms were introduced, resources flowed out of central London hospitals to those in less costly and more accessible surrounding areas. This change threatened the sustainability of some central London hospitals, leading to the suspension of the internal market in London and a review of health services in the UK capital led by Sir Bernard Tomlinson. The review gave greater priority to community and primary care services, while London's hospitals were given more resources to enable them to cope with the changes. Eventually, some hospitals were closed or rationalized. Thus, while a combination of market signals and government management led to a more orderly process of change than might otherwise have been the case, the market nonetheless had an impact. Ham (1996b) claims that other major cities experienced similar changes, but at slower paces than in London.

While a combination of market signals and government management led to a more orderly process of change in the United Kingdom than may otherwise have been the case, the market nonetheless had an impact.

With respect to access to care, British Household Panel Survey data, analyzed by Propper (1998), shows that the pattern of use of GP and inpatient services remained stable between the first quarter of 1990 (before the reforms) and the

fourth quarter of 1993 (two years after the reforms). After adjusting for indicators of need, use was still slightly in favor of the poor. Thus, the level of equity (or inequity) in health care delivery remained largely unaffected by the change in health care purchasing.

The UK internal market reforms appear to have led to the establishment of clearer roles for health authorities and providers, encouraging them to become more cost conscious and considerate about what to provide, to whom, and at what standard.

The internal market reforms also appear to have led to the establishment of clearer roles for health authorities and providers, encouraging them to become more cost conscious and considerate about what to provide, to whom, and at what standard (Le Grand 1999). Undoubtedly, in the United Kingdom, those reforms also led to a change in the role of GPs, who are now very closely involved in many decisions about service provision (ibid.). Bergman (1998) states that both purchasers and providers have a preference for maintaining the split over returning to the older system.

It is easy to conclude that the UK reforms (and perhaps to a lesser extent, those in Sweden) were a flop. On the positive side, however, the reforms did show potential to reconfigure services in a way that was more in line with population needs — for example, in the placing of greater emphasis on primary care. It is difficult to go any further in assessing these reforms as they were implemented in a way that prevented full evaluation.

Potential for Implementation in Canada

The potential for turning health authorities into purchasers does exist in Canada and has, indeed, been proposed (Blomqvist 1995; Jérôme-Forget and Forget 1998). Health authorities now exist in most provinces, and the fact that so much of Canada's health care is consumed in and around large cities — 50 percent of the population lives in the 15 largest metropolitan areas — allows for potential competition among providers.

Some great challenges have to be overcome, however, if the role of health authorities is to be enhanced in this way. First, it is not clear whether, as an institution, health authorities in Canada are mature enough to take on such a major role. Second, the remuneration system for hospital doctors would likely have to change if an internal market were established here. If providers were to commit to contracts established with health authorities, more control would have to be exerted over those who work in provider units. Ultimately, this would require doctors to be employed by, or contracted to, such units. This change would be particularly challenging in Canada, as the current system of remuneration is highly entrenched in the medical culture.

Hospitals as Providers

Another possible reform of the internal market would involve converting providers of hospital and community health services into independent trusts — the term used in the United Kingdom; in New Zealand, they became Crown Health Enterprises — separate from the local health authorities but still part of the health care system. Generally, trusts' incomes depend on their ability to attract business from local health authorities as well as GP fundholders (see below). Because they compete for custom with other providers, they have an incentive to provide

quality health care at attractive rates. While the aim of making health authorities into purchasers is to overcome the first and second perverse incentives outlined in the previous section -- that is, to reward quality service provision, and to leave hospitals to deal with the details of micro-management while health authorities address issues related to population needs — the establishment of trusts addresses the second and third disincentives. If physicians are employed by hospitals, then they, and the hospitals themselves, should become more financially responsible.

Trusts could also be given freedom to negotiate their own rates of pay. Where they were established in the United Kingdom, they were permitted to develop new services without the direct involvement of the health authority — although, at some stage, the health authority had to be involved if it was going to purchase the service. Trusts were not permitted to retain budgetary surpluses, but they had to make a real return of at least 6 percent on their capital assets, as they were responsible for payment for these assets.

Freeing trusts from direct management by the health authority was meant to allow them to become more responsive to patients' needs as expressed by health authority purchasers and, in the United Kingdom, to create "a stronger sense of ownership and pride" (United Kingdom 1989). The fact that those who worked within the trusts were their direct employees could allow greater control over costs and over decisions regarding what services to provide. Thus, quality would be maintained or improved at lower cost through the mechanisms of having to meet the requirements of purchasers while keeping within budget and making some decisions at a level closer to patients rather than at the level of the health authority.

Evidence on Efficiency and Equity

In the United Kingdom, within six years of the creation of the internal market, all providers of health care had become NHS trusts.

In the United Kingdom, within six years of the creation of the internal market, all providers of health care had become NHS trusts. There is a paucity of research on hospitals as providers, but what there is appears to indicate that the objectives for which trusts were introduced were not met. This is largely because there was little supply-side competition, even though, as discussed above, the conditions for it did actually exist, at least in the United Kingdom (Appleby et al. 1994).

Trusts tended to be granted less freedom than managers had expected. Access to new sources of capital was restricted, and national pay bargaining was largely maintained. The government tended to intervene to limit competition, despite having introduced the reforms to encourage such competition (ibid.). In New Zealand, the law establishing Crown Health Enterprises explicitly stated that they should act in a "socially responsible" manner (Scott 1994). What emerged was a series of bilateral monopolies, with large health authorities on one side and large providers on the other negotiating deals, much like under the old systems (Propper 1995). The main route to increased efficiency was to give the trusts an annual budget, or a block contract, and attempt to extract ever-increasing volumes of patient care from it (Paton 1995).

Ham (1996b) is more positive about this aspect of the reform, too, claiming that in the United Kingdom it encouraged providers to assess their strengths and weaknesses relative to competitors. The need for such assessments was strengthened by the growing interest of private providers in gaining NHS

contracts, although the vast majority of contracts remained within NHS providers. Trusts in the United Kingdom also displayed great potential for change by becoming more responsive to GP fundholders (see below). GPs tended to contract on a case-by-case basis, which trusts saw as a source of revenue additional to block contracts. As a result, GPs were perhaps more effective purchasers than health authorities — although it could be argued that, while the stability provided by health authority funding allowed this more aggressive purchasing on the margins, it would not have worked for the system as a whole. It should not be forgotten, however, that system-level efficiencies were achieved in those county councils in Sweden that did implement the reforms (Gerdtham, Rehnberg, and Tambour 1999).

In summary, not much competition arose between trusts in the United Kingdom, mainly because of central government regulation. On the positive side, however, trusts did have to justify themselves to purchasers, the potential for competition did exist, and trusts did show themselves to be responsive to GP fundholders. Thus, the potential for quality improvements was there, but it is difficult to assess from a population perspective. Changes in doctors' behavior as a result of their becoming hospital employees are also difficult to assess, as their basic form of remuneration, by salary, did not change.

Potential for Implementation in Canada

The challenges of introducing trusts into the Canadian health care system are very similar to those for establishing health authorities as purchasers. Hospitals in large urban centers, where most of the population lives, have the potential to compete with one another. For this to happen effectively, however, the method of remunerating hospital doctors would likely have to change. It would be difficult for providers to commit to contracts with health authorities on costs and volumes of care to be provided without being able to exert more control over, or at least to establish, a united financial front with the main drivers of resource use in provider units — that is, doctors. This would require doctors to be employed by, or contracted to, such units.

General Practitioners as Purchasers

GP fundholding was intended to overcome the disincentive whereby physicians direct a lot of health care activity with no financial repercussions for themselves and no financial incentive to concern themselves with its quality.

The third element of the United Kingdom's 1991 reforms is known as GP fundholding. Under this arrangement, GPs act as purchasers of hospital care and some other types of care for their patients. Fundholder practices are given a budget (which comes out of the local health authority's funding allocation) from which to purchase care for their patients, including a limited range of hospital services, specialist services, and drugs.

GP fundholding was intended to overcome the third main disincentive discussed earlier, whereby physicians direct a lot of health care activity with no financial repercussions for themselves and no financial incentive to concern themselves with its quality. Again, the theme of separating the purchase and the provision of care is the underlying premise. It was also believed that GPs would be more effective purchasers for their patients than a health authority manager. The GP was closer to patients and thus presumably could effectively meet their needs;

the GP was also more able to negotiate with local hospitals. The theory was that the need for GPs to keep within budget and patients' ability to change doctors would lead to greater fiscal responsibility and improvements in quality. It is an approach that comes close to Flood's managed-care model, but is still limited by the restricted range of services over which GP fundholders had jurisdiction (Flood 2000).

Entry into the UK GP fundholding scheme was voluntary. Initially, it was open only to practices with 11,000 or more patients. Later, smaller practices with patient lists as low as 5,000 were allowed to join. By 1997, half the population was covered by fundholding practices, which controlled more than 10 percent of hospital and community health service spending. The fundholding system evolved further: community fundholding was introduced, extending the range of services purchased by the fundholder, and some fundholders formed consortia or pooled their resources more formally as multi-fundholders (Goodwin et al. 1998).

Fundholding introduced a financial incentive for those who joined the scheme to be more efficient.

Fundholding introduced a financial incentive for those who joined the scheme to be more efficient: they were able to invest any savings from their budgets in improvements in patient care or practice improvement. Fundholders could also move funds between components of the budget, allocating resources as they saw fit. Any fundholders that repeatedly failed to meet the budget risked losing fundholding status. On the other hand, there was a limit to the financial liability of the fundholding practice from patient selection risk: if expenditure on a given patient exceeded a certain amount (£5,000) then the local health authority took responsibility for the excess spending.

The budgets were set on the basis of historical costs initially. This method was criticized, however, for rewarding inefficient practices (Baines, Tolley, and Whynes 1997). It had been intended that a form of capitation eventually would be used, and in the fourth quarter of 1993 simple versions of a weighted capititation method that accounted for age were employed. Later, more complex weighting schemes, accounting for age, sex, and the number of temporary residents in a region, were introduced (Baines,Tolley, and Whynes 1997).

Evidence on Efficiency and Equity

General practice fundholding is one of the most studied of the United Kingdom's 1991 reforms. Evaluation of this system still suffers, however, from a lack of planning and rigor. Further, the existing empirical evidence is plagued by a series of problems that make it difficult to draw firm conclusions.

First, as has been pointed out, a series of changes in the NHS were introduced at around the same time. This makes it impossible to attribute any observed changes to fundholding alone.

Second, the feature that practices voluntarily self-selected into the fundholding scheme confounds the evaluation; fundholders tended to have better resources and to be in more affluent areas than nonfundholders, so they are not a random sample (Petchey 1995). There is documented evidence that the practices that entered the fundholding scheme in the first wave were measurably different from those that entered later (Baines et al. 1997; Whynes, Baines, and Tolley 1997; Baines and Whynes 1996). Thus, the differences between fundholders and nonfundholders may not be attributable to fundholding status *per se* but to other, unmeasured, differences.

Third, potential fundholders had an incentive to engage in strategic behavior. Since budgets initially were set on an historical basis, potential fundholders could have an incentive to inflate their budgets in the year prior to becoming fundholders to enable them to reap definite savings in their first fundholding year (Baines, Tolley, and Whynes 1997). There is no empirical evidence to support this, however, at least in the area of prescriptions (Whynes, Hron, and Avery 1997; Whynes, Baines, and Tolley 1997).

There are no studies that directly assess the technical or allocative efficiency of GP fundholding, but there is a body of empirical literature assessing various specific issues related to efficiency and fundholding. This literature has recently been comprehensively reviewed by Goodwin et al. (1998).[4]

One of the most studied aspects of fundholding was the impact it had on GPs' prescribing behavior. In the United Kingdom, most drug consumption is paid for from the NHS budget; non-exempt patients pay a small fixed fee.[5] Reducing the drug budget was one of the key objectives of fundholding. There is some consensus among analysts that fundholders were able to curb the rise in prescription costs compared with non-fundholders, at least initially. This reduction was a result of lower per prescription costs, achieved through such measures as increased use of generic alternatives, rather than through a reduction in the number of prescriptions. After the first few years of fundholding, cost reductions leveled off. One would expect savings to become more difficult to achieve given that the obvious cost-reducing measures had already been implemented.

Fundholders were able to curb the rise in prescription costs compared with non-fundholders, at least initially.

Another aspect of fundholding that received some attention in the literature was its impact on the rate of referrals to specialists and on the use of emergency care. It was hoped that holding GPs financially responsible for their referral decisions would reduce inappropriate referrals, thus freeing up resources for more appropriate use. On the other hand, there was also concern that fundholders might have an incentive to shift costs to the health authority, by referring patients to emergency care, which was funded by the health authority budget. The small body of literature on these issues is inconclusive; it appears that in England rates of referral to specialists did not alter after the introduction of fundholding, while in Scotland the introduction of the scheme did lead to reduced referral rates for certain groups (Coulter and Bradlow 1993; Howie, Heaney, and Maxwell 1994).

Other results on fundholding relate to the location of care, to administrative costs, and to the investment of any surpluses. It appears that more services, such as outreach clinics staffed by hospital clinicians, were provided by fundholding practices after they became fundholders, resulting in a shift in the location of secondary care. It is not clear, however, that this is attributable to fundholding *per se*. Further, it has not been demonstrated that this development represents an efficiency improvement. The administrative costs of fundholding are high; some estimates suggest that they are not outweighed by any cost savings.

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4 For a complete list of references evaluating fundholding, see the reference list contained within Goodwin's comprehensive review.

5 The exempt include children, the elderly, pregnant or new mothers, and recipients of social security.

With respect to the effect of fundholding on equity, there were two areas of concern. First, some observers worried about the potential for "cream skimming": the incentive for fundholders to select only healthy patients, since ill patients would jeopardize the fundholders' ability to make savings on their budget. There is no evidence that this practice became an issue, however, likely because of the provision limiting the per patient liability of the fundholder to £5,000 per annum. The second concern was that, since fundholding did not cover all GPs, patients of fundholders might receive preferential access to care because of their improved ability to negotiate favorable terms with hospitals. There is some evidence that such a two-tiered access to care did in fact occur. In 1997, the new Labour government replaced fundholding with a system of primary care groups, which were responsible for the purchase of hospital, community, and primary care for their populations. These primary care groups did cover all the GPs, and cooperation rather than competition was encouraged between purchasers and providers. This change also made it less clear where the financial power and responsibility lay — with the health authority or with the primary care groups — thus diluting the incentive effects of the reform. Similar groups have been proposed in Ontario (Health Services Restructuring Commission 1999), although they do not cover as comprehensive a range of services as those in the United Kingdom.

In summary, the evidence once again is not clear cut. It could be argued, however, that fundholding, by giving greater financial responsibility to GPs and allowing patients to change doctors, displayed the greatest potential of all the UK reforms to improve efficiency in health care provision.

Fundholding, by giving greater financial responsibility to GPs and allowing patients to change doctors, displayed the greatest potential of all the UK reforms to improve efficiency in health care provision.

Potential for Implementation in Canada

In Canada, implementing a similar system, where physicians act as purchasers for their patients, would present significant challenges. In the first place, primary care physicians would have to be willing to accept an alteration in the reimbursement system, from the current fee-for-service scheme to a form of capitation. As this form of payment would involve more income risk, it might require higher overall payments to compensate physicians for the increased riskiness of their incomes (Emery, Auld, and Lu 1999). Perhaps there is potential for a payment mechanism that combines fundholding and fee for service, which would provide physicians some financial incentives more closely related to their decisions without raising their level of risk unduly.

Consumers, too, would have accept to rostering — that is, registering with a general practice that, in most circumstances, would be their first point of contact with the system. Jérôme-Forget and Forget (1998) note that this presents a challenge to the implementation of fundholding, as Canadians are used to being free to choose their own doctors.

Another issue is whether or not a fundholding system would work in more remote areas where competition will not really manifest itself, since budget-holding primary care physicians would not have multiple providers with which to contract. The other side of this coin is whether Canadians would be willing to accept the implications of competition in urban areas, such as the closing of some

hospitals. When this issue arose in London, the UK government intervened and suspended the quasi-market (Mays, Mulligan, and Goodwin 2000).

One area in which the empirical evidence seems most to favor fundholding is its impact on prescribing. Currently, in Canada, drugs are not part of the public health budget, except those provided in hospital or through government programs for special groups, such as seniors or those on social assistance. Otherwise, drugs are paid for by consumers or by private insurance, and physicians bear no fiscal responsibility even for such drugs as are publicly funded. Thus, the payment system for drugs in Canada would have to change if this reform is to be implemented. A final point here is that if a form of fundholding were to be implemented in Canada, it would be possible to include publicly funded drugs in the scheme.

Medical Savings Accounts: Increasing the Role of Consumers

Medical savings accounts would put more control of health care spending into the hands of individual patients by enabling them to purchase health services directly through funds held in their account.

The idea behind medical savings accounts is to put more control of health care spending into the hands of individual patients by enabling them to purchase health services directly through funds held in their account (Gardner 1995). Each person is allotted a certain amount per year to pay for routine medical services. When the amount in the account is exhausted, the individual is required to pay for medical services out of pocket, up to a maximum limit (Gratzer 1999).

This reform is aimed at addressing the fourth main disincentive described earlier, by having individual consumers take account of the financial consequences of their actions. The idea is that costs are controlled and services are more likely to be provided in line with consumer preferences. Exceptions would be made for catastrophic circumstances, for which individuals would pay, out of their yearly allotment, high-deductible insurance to cover serious medical problems, as defined by a certain dollar amount (Grimaldi 1996).

Some argue that such a reform would allow individuals to take more responsibility for their own health care consumption, as each person would actually pay out of his or her account for the services received (Gramm 1994; Gratzer 1999). One school suggests that, currently, with zero cost at the point of consumption for most health care services, the investment people have in their own health is limited. Consumers do not, in terms of resources, have an incentive to act judiciously. It may be that if consumers are required to pay for services at the point of consumption, they would invest more time and effort in knowledge about their particular health conditions. This investment would support the aim of ensuring more appropriate care, as well as potentially more efficient use of resources.

Nonfinancial incentives already exist for individuals to use health care services wisely. What is not clear is whether there are additional gains to be had from adding financial incentives. The extent to which the general public can comprehend the sometimes complex medical issues well enough to respond appropriately to these financial incentives and the extent to which individuals actually want a more hands-on role in medical decisionmaking are also uncertain. Clearly, before introducing a reform along the lines of medical savings accounts , these fundamental questions would have to be explored, through survey work and

limited piloting, including a systematic look at the extent and cause of inappropriate use in the system.

It is also unclear whether such a system would introduce greater equity problems with regard to access to services. With this model, since everyone would receive the same amount to spend on their health care (or perhaps an amount adjusted for age or socioeconomic status), those with higher incomes would not necessarily benefit, except to the extent that they are more likely to be healthy and therefore less likely to use all their funds in a given year.

Medical savings accounts allow individuals more control over minor medical expenses while protecting them, through catastrophic insurance, from major financial penalties in the case of accidents or serious illness.

The concept of medical savings accounts, at least in theory, thus allows individuals more control over minor medical expenses, such as GP visits, while protecting them, through catastrophic insurance, from major financial penalties in the case of accidents or serious illness.

Many questions necessarily arise about the details of how a medical savings account system would work, and there are many potential variants of this approach. For example, where would the money for the accounts come from? Most likely, provincial governments would collect the current amount of tax, then deposit a portion of the tax bill directly into each individual's medical savings accounts and use the remainder to fund catastrophic care. What would happen to any leftover funds in someone's account each year? One model might be to give people the option of rolling over any unused portion to the next year, or of withdrawing the unused amount for personal spending. If the former approach was taken, the money could be invested in the form of a registered retirement savings plan-like mutual fund, which could grow tax free over many years until retirement. This would also enable people to save for future medical expenses that may arise in old age.

Another question is how the accounts and withdrawals would be administered. It is feasible to imagine Interac-style debit cards, with authorized medical providers having some type of bank machine to process automatic payments.

Evidence from the Literature

While medical savings accounts are a relatively new concept, a fair number of published papers, primarily from the United States, have discussed their impact on a health care system. Unfortunately, there appear to be no published studies that explicitly examine such a system's *actual* costs (to society and to the patient). As with the other reforms we have reviewed, there is little information on which to judge impact on patient health outcomes. Simulation studies and descriptive pieces do not provide adequate evidence to evoke calls for reform. The majority of US studies on medical savings accounts relate more to employer and health system costs then to patient outcomes, probably because these are areas of concern for policymakers facing escalating costs.

Nonetheless, we review here a few relevant empirical studies, while noting that any transfer of US results to Canada must be carried out with caution, because the two countries' health systems have such inherently different structures (largely market based insurance versus single payer). Further, even if a system of medical savings accounts resulted in benefits to Canada, significant changes to the Canadian health system would be needed for these benefits to be realized. We outline some of these changes following the review of the pertinent literature.

Keeler et al. (1996) examines the impact of medical savings accounts on 23,157 sampled households through the RAND Health Expenditures Simulation Model. In this model, a number of options were explored, including the level of the catastrophic deductible and variations in how the accounts were funded. Taking into account the fact that, in the United States, the medical savings account scheme is voluntary and that not all Americans would choose this approach, the analysis finds that health spending would change by between +1 percent to –2 percent. Thus, this modeling study suggests that implementing a system of medical savings accounts would have little impact on overall health care costs in the United States. However, without information on patient outcomes, it is not possible to determine whether or not such a system would lead to more efficient service provision.

One cross-sectional study of non-elderly adults compared comprehensive insurance and a combination of medical savings accounts with catastrophic insurance (Ozanne 1996). The findings suggest that medical spending would be reduced by between 2 percent and 8 percent with the medical savings account/catastrophic insurance option. However, as Grimaldi (1996) points out in the context of the elderly US Medicare population, this approach would likely appeal to only a small segment of that population, thus reducing the potential overall savings. This caution on the selection issue also applies to the non-elderly, whereby the cost per head of insuring those remaining in the insurance pool (who are more likely to be sicker) may rise.

Limited evidence from other countries does not clear up the unresolved issues from the US literature. Singapore has integrated medical saving accounts into its health system, but reports differ on the effectiveness of this reform (Hurley 2000). For example, Hsiao states that Singaporean hospitals did not start competing on price, and that the per capita cost of health care rose faster after the introduction of the new health care model that included medical savings accounts than it had before (Hsiao 1995). Another study states, however, that costs were controlled following the introduction of this reform (Massaro and Wong 1995). One of the most meaningful comments from this literature is a recommendation for the piloting of medical savings accounts at the local or regional level before fully implementing this reform (ibid.).

China has also started to use medical saving accounts, to a more limited degree. Again, however, actual assessment remains elusive (Hurley 2000). One paper finds that, while medical savings accounts hold promise as a viable model of health care finance, it does bring with it the potential for risk selection, cost shifting, and reduction in equity (Yip and Hsiao 1997). Further, in recommendations for other countries, these authors state that implementing such a reform also requires supply-side reforms. As with the US literature, none of these papers on Singapore and China assesses changes to health outcomes; it is not possible to judge whether a reform would lead to improved efficiency without information on both costs and outcomes.

No studies, even those of a preliminary nature, of the potential impact of medical savings accounts in Canada have been conducted.

To our knowledge, no studies, even those of a preliminary nature, of the potential impact of medical savings accounts in Canada have been conducted. Gratzer, however, in his recent book, *Code Blue* (1999), puts a passionate case for introducing such a reform. In theory, his argument does make some sense, but the evidence he cites in favor of this approach is quite weak. It is driven by the

premise that overutilization by consumers is the root cause of the health system's problems, with little consideration of the other misaligned incentives identified earlier in this paper. Much of Gratzer's case is built on anecdotes and examples of individual organizations in the United States that use medical savings accounts. Unfortunately, since no hard data on health outcomes are available, it is simply not clear what impact such an approach would have on individuals. Further, as mentioned above, citing cases from the United States as evidence that applies directly to Canadian health care may not yield valid results, because the two systems are so inherently different.

A recent review article by Hurley (2000) states that, while no unambiguous evidence either for or against medical saving accounts exists, it is possible to draw on empirical evidence for other demand-side incentives such as user charges. Most notably, Hurley argues that medical saving accounts are unlikely to control expenditures, and in fact implementation could actually lead to increased overall spending. The thinking behind this suggestion is that individual purchasing is less influential than that of large-scale insurers and that, consequently, less fiscal control could be exerted over the everyday health care expenses covered by the accounts, while catastrophic problems would continue to be funded through conventional means.

One argument against the savings-account approach is that it would likely compromise the equity of the health care system, particularly if unused portions of the account could be rolled over for use in nonhealth sectors.

One further argument against the savings-account approach is that it would likely compromise the equity of the health care system, particularly if unused portions of the account could be rolled over for use in nonhealth sectors. In this case, individuals conceivably could face a choice between health care and other goods; for those who can afford the other goods, this would pose no problem, but for the poor, health might be sacrificed to purchase other goods. If this model were to be adopted in Canada, some limit on withdrawals of unused amounts would likely be imposed.

Potential for Implementation in Canada

While implementing medical savings accounts would involve many practical challenges, several more fundamental structural issues would also have to be addressed in Canada before the benefits of such an approach could be realized. Already, Canadians have some ability to choose among providers (family physicians, and even specialists or hospitals to a lesser extent).[6] As a result, the advantage of consumer choice that this system offers may not be a significant issue in Canada. This key point is unfortunately not recognized by Gratzer (1999), who assumes that certain outcomes witnessed in the United States would be directly transferrable to Canada. (Of course, adding price to the mix of things people consider when they "shop around" could improve this process.)

As for the suggestion that medical savings accounts might encourage consumers to invest more in their own health choices, it is also true that Canadian consumers already have the ability to invest in their own health outside of medical care.

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6 Certainly, consumers are not able to detect perfectly the quality of a particular provider. They may, however, be able to infer some (imperfect) information about quality from some observable characteristics of the provider, though they will differ in their ability to draw these conclusions.

Another limit on the potential for gain from this reform is the problem of asymmetrical information in health care. Because they are not as well informed as providers, it is difficult for many consumers to make fully informed decisions. In the medical savings account model, if an individual disagrees with a physician's assessment, the individual can (or even should) keep shopping around to find the alternative that he or she judges to be most cost effective, taking into consideration both the potential benefits and costs of the alternatives (Gramm 1994). It is not clear if, in practice, the average person could make this kind of informed decision. Health care consumers do not always know what they need; particularly in times of duress, such as when they are ill, they may not even know what they want (Stacy 1994).

Asymmetry of information is one of several elements put forth in the argument as to why there is the potential for market failure in health care (Donaldson and Gerard 1993). One further important point is that the ability and willingness to take on the role of "consumer of health care" is likely to vary across socioeconomic and age groups, which raises further equity issues (Lupton, Donaldson, and Lloyd 1991; Donaldson, Lloyd, and Lupton 1991).

Valid and reliable piloting of the medical savings account model in a Canadian setting would certainly be required before fully informed judgments about its impact can be made.

Another difficulty with such a consumerist model of health care is that, if governments simply allocated the same amount to health care as they do now but gave the money directly to consumers instead of to health authorities, the total amount spent on health care would not change. Consumer expectations would, however, likely change. Therefore, waiting lists are unlikely to be reduced. The nature of the "contract" between consumer and provider would have altered, and consumers would likely expect quicker access once diagnosed with a condition requiring treatment. The legal implications of this kind of contract may be quite different from those of the current system.

Conclusions

Canada's health care system is in a straitjacket. Neither recent increases in public funding nor a gradual trend toward more private financing are satisfactory solutions.

Canada's health care system is in a straitjacket. Neither recent increases in public funding nor a gradual trend toward more private financing are satisfactory solutions, in our view.

Should Canada move toward a more financially integrated system by means of the reforms discussed here, which have been implemented in Europe and elsewhere in the past decade? Certainly, such reforms could not be achieved here without major changes to the structure of health care. Some may argue that the results of these reforms are not encouraging enough to warrant bringing them to Canada. It could also be argued, however, that, in some jurisdictions, the reforms were never truly implemented, while in others, such as Sweden and major UK cities, they have been relatively successful. Some aspects of these reforms have shown potential, which would indicate that they should at least be tested in the Canadian setting.

Many of the reforms we have described were introduced wholesale, without any thought being given to their evaluation. This situation has contributed to the

ambiguity of the evidence base. A controlled pilot program, on a geographic basis, either within or across provinces, would be warranted before proceeding further with any of these reforms. Furthermore, it may be better to introduce the reforms on a gradual basis. There has been movement toward regionalization in Canada over the past five to seven years. It may not be possible to move to an internal market in health care without having had a regional structure in place for some time.

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Without financial integration, a truly seamless health care system can never be reached, as financial incentives will never be aligned. Implementing the necessary reforms would require a great deal of courage on the part of many groups: politicians, who would need to change the structure of the system; doctors, who would need to accept major changes to the way they are remunerated; and other health care organizers and policymakers, who would need to apply the same amount of rigor and experimentation to changes in the health care delivery systems as they apply to the evaluation of new medical interventions, such as drugs.

More specifically, moving to a more financially integrated system would involve facing some or all of the following:

- The public may have to accept rostering in general practice — individuals would be attached to a primary care doctor or practice for a fixed amount of time, and only in exceptional circumstances could they visit another GP during that period.
- Hospital doctors would have to accept becoming employees of, or contractors to, the health care system (meaning, primarily, hospitals).
- GPs would have to accept a change in the way they are remunerated, perhaps going as far as accepting an annual budget for all of the care of the patients on their roster, from which they would also derive an income.
- GPs and health authorities would have to shift their thinking to accommodate a population-based perspective on health care planning.
- Politicians would have to accept that GPs and health authorities will have to make some tough choices when managing their budgets.
- The *Canada Health Act* may have to change to cover more services and to allow for private administration of government funds.
- The nature of the "contractual" relationship between health care consumers and health care providers may change; the legal implications of this change are still unclear.

These are huge challenges. In our view, however, they are precisely the ones some brave people will have to face. Band-aid solutions, such as increased health care funding, may keep the system going, and they remain an option as long as the economy is strong and budget surpluses continue. Over the longer term, however, there is potential for Canadian health care to offer higher quality at lower cost if it breaks out of the straitjacket it is in, with reforms that better align incentives through integrated financing.

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